Health Canada Santé Canada

Rural Women and Substance Use: Issues and Implications for Programming

Canada

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Office of Alcohol, Drugs
and Dependency Issues
Health Promotion and Programs Branch
Health Canada

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I.
Introduction

Background

Women have been identified as a priority population under Phase II of Canada's Drug Strategy. Substance use needs and issues for rural women were discussed at both the *Roundtable on Women and Substance Use, Misuse, and Abuse* coordinated by Health Canada in October of 1993 and *Working Together. A National Workshop for Action on Women and Substance Use* held in February 1994. It was noted that rural communities often lack adequate resources to deal effectively with issues and problems surrounding substance use. In addition to the lack of effective resources, rural women's risk can be compounded by issues such as social isolation, family violence, economic uncertainty and high levels of stress. Key informants have also indicated that health and social service workers would benefit from information on effective models and methods to address substance use problems among rural women.

Consequently, the Office of Alcohol, Drugs and Dependency Issues partnered with the Women's Health Bureau, Women and Tobacco Reduction Programs, and the Work and Education Health Promotion Unit to address this need. Research was conducted on existing North American substance use programs, models, and issues for women in rural communities to identify key components of effective programs ranging from prevention to treatment for tobacco, alcohol, and other drugs. The work included a literature review as well as contacts with key informants and program deliverers to identify key issues and substance use programs for rural women. The background work was then synthesized and

augmented to include resource lists and additional programs from related areas, such as prenatal health and AIDS, which use effective strategies to address geographic and social isolation in rural areas. This report, therefore, summarizes and builds on earlier work.

Definitions

Rural women refers to adult women (age 16-plus) who live and work in rural settings including farms, hamlets, villages and small towns. In 1991, 23.4% of the population in Canada was considered rural, i.e., living outside urban areas with a population concentration of 1,000 or more and a population density of 400 or more per square kilometre (Statistics Canada, 1993).

This report does not include Aboriginal women living on reserves and in rural communities in the North. The Aboriginal women's community in Canada has developed unique and culturally responsive approaches to substance use problems. While all of us can learn from these approaches, an effort to describe Aboriginal women's issues and model programs was believed to be a task for a separate project. A workshop on Aboriginal women's health was held in September 1995.

Substance use problems refers to the problematic use of alcohol and medications and the use of illicit drugs and tobacco.

Substance use programs refers to organized activities for individuals or groups in community settings other than schools. Programs deal with prevention, intervention, protection and treatment or cessation.

About This Report

The objectives of this report are to:

1. Explore the life circumstances of rural women and issues related to rural living and women's problematic use of alcohol, tobacco, medications and illicit drugs.
2. Examine related programs for rural women to draw out important learnings for future programming.
3. Suggest solutions for overcoming barriers to programming in rural settings.
4. Provide an initial list of resource materials and contacts for health and social service providers.

Sections II and III draw on the literature to discus the life circumstances of rural women and some of the program and service issues they face. Section IV describes a number of programs that provide insights into the design of programs for women in rural settings. Section V presents an analysis and summary of what was learned from the literature and program review. Section VI list and briefly describes some key resource materials. The Appendix lists some key contacts that address the needs of women in rural communities.

II.
The Life Circumstances of Rural Women

Rural women are as diverse as any other group of women in Canada. However, many of them share the stresses that are common to life and livelihood in a rural setting. The purpose of this section is to discuss some of the realities of day-to-day living for rural women.

In Canada, rural women are found mainly on farms but also in small towns and villages: farm service centres, forest industry towns, fishing villages, mining settlements, etc. Women make up 25% of the total number of farm operators, amounting to some 100,320 women across Canada (Statistics Canada, 1992).

The Status of Rural Women

Many of us have a mental image of life in rural areas as peaceful and pastoral. In reality, however, the lives of rural women today are nothing like our idyllic images. Rural women in Canada are very likely to experience severe financial, work, environmental and social stresses that are exacerbated by a lack of political and economic control.

Lack of control is a major stress for rural women. International and national marketing decisions in grain pricing, fish stocks, free trade, railroad policies, interest rates, farm support, environmental policies, health care reform and unemployment all have a direct effect on how these women live. At the local level, distance often makes it difficult to communicate with regional or municipal governments.

The low status of rural women is also an issue in industry. Rural women are often excluded from planning for economic development by industries such as mining, logging, pulp and paper, agriculture, fishing and fish processing. In the agricultural industry, rural women suffer from a lack of recognition and leadership positions. Bankers, sales representatives, managers, community leaders and bureaucrats often exclude farm women from their definitions of leaders and operators (Berntson, 1993).

Many rural communities also espouse traditional stereotyping of gender roles. Male spouses and relatives tend to hold traditional images of women that are at odds with their contributions and leadership roles. In one leadership development project in a rural area, 63% of women and 9% of men said that gender was a barrier to the development of leadership in their experience. Sternweiss and Wells (1992) speculate that "gender may be an externally imposed barrier, part of a male construction of reality or a nonconscious sex role ideology, rather than being created by the women themselves."

As a result of sex role constraints, many rural women perceive themselves as not having the interpersonal power to affect decision-making (Berntson, 1993). As expressed by one farm woman, "Being systematically underrated and unrecognized frequently contributes to our lower expectations, lack of self-confidence and low self-esteem" (Wiebe, 1987).

In terms of socioeconomic status, there are both regional and individual differences and disparities. *Farm Family Health* (Health Canada, 1994) reports that, in parts of Ontario, farm women are better educated than urban women and are more likely to be professionally employed and able to use health information for their own and their families' benefit. Another report, from the U.S. National Rural Alcohol and Drug Abuse Network, (*Fact Sheets*, 1990), gives a different regional picture of rural women: increasing poverty (67% of substandard housing is found in rural areas), increasing reports of child abuse and woman-

battering, increases in diagnoses of depression and anxiety disorders, decreasing living standards and lower employment rates (unemployment 50% higher. than in rural areas). Many women living in rural parts of Canada (especially where unemployment is high) live in conditions similar to these.

Effects of Geography, Time and Distance

Fatigue and exhaustion are common outcomes of the staggering workloads faced by many rural women. Some work 95 to 105 hours per week, dividing their time among farm work, off-farm jobs, household work and child-care. Many women work off-farm to supplement inadequate farm incomes. One 1990 survey (Danes and Keskinen, 1990) reported that 46% of farm women were employed off the farm. Their average hourly wage was $6.32 and the average distance to work was 26 miles.

These enormous time constraints make certain activities impossible (Johnson, 1988; McLaughlin and Church, 1992). For example, many women fail to attend treatment after-care activities because they have too much to do. Many are unable to provide the social support and volunteer time that have been traditional roles for women in rural communities.

Rural women who are unemployed (or whose partners are unemployed) face different Kinds of time constraints. Stress and relationship problems related to unemployment and a lack of financial resources can preoccupy their time. Many of these women see their need for help as a lower priority than sorting out other family difficulties.

Distance is also a significant barrier. Access to programs, resources and services are limited by distance and the lack of public transportation. One study reported women driving up to 45 miles to attend group meetings (Andrews, 1987). Driving is expensive and stressful for anyone, particularly in bad weather or in remote areas with poor roads. Distance also means that neighbours and support groups of other women may be out of reach.

Social Isolation

The belief that distance and small town social structures inevitably cause social isolation is a myth of rural life. Most women can deal with periods of social aloneness as long as it is of limited duration—a snowstorm, for example, or a significant other gone for a few weeks or months. "Research has shown that whether a farm woman really feels socially isolated depends more on the kinds of relationships she has with her spouse and her friends than just on geographical distance" (Wiebe, 1987).

Social isolation is an outcome of feeling unconnected—to others and to oneself. Women who feel unconnected, rejected or unable to act on their own needs feel isolated. Choice and the ability to take control of one's life mitigate these feelings of isolation. This is empowerment.

Other social factors exacerbate feelings of isolation. Unemployment and chronic poverty can cause individuals and families to be left out of the rural ethic of neighbourly support. A belief in the axiom "we're not so poor that we can't help" can cause some rural families to shuffle priorities in order to appear capable of assisting others. Health needs may become nonessentials to protect the family's reputation: women may go without eyeglasses, proper nutrition, medication or health services that require payment such as chiropractic services and dentistry.

Family Violence

Family Violence is another disconnecter for rural women. Barbara Quinn (1994) writes eloquently of her isolation while the batterer is still included in the life of the community:

> *Sure he's a nice guy. He's a fun-time drinking pal. Good at helping out at the rink. A great hand at branding cattle or skinning deer. But after he got drunk with you, he came home and took out all of his frustrations on me.*
>
> *I know you don't understand. You see only what you want to. You welcome him into the community fold as if there is no problem. You slap him on the back at the*

hockey game and feel sorry for him living on his own. You ask him over for supper and include him on your curling team.

And me? Well, I'm the outsider now. I'm the bad guy who called the cops and went through the courts. I'm the one who gave him a criminal record for assault and I'm the one who can never go home. You've chosen to turn from me to keep peace in the extended family of that small community. You still have to live there and I'm gone, making a new life for myself because, after all, I never really fit in anyway.

I'm angry and I'm hurt. I miss my kitchen, long for my community and I mourn my lost marriage. But more than that, I feel betrayed.

When rural women are victimized by violence, the barriers of distance loom large. Protection from police or the nearest shelter may be miles away. If a woman does not have access to a vehicle, leaving the situation is extremely difficult. As Barbara Quinn makes clear, being terrified by the most significant person in her life leaves a woman feeling cut off, with little control and few choices.

Rural attitudes toward seeking help can further exacerbate isolation. In many rural areas, there is an ethic of managing your own problems. It is least acceptable to seek help for two types of problems: discord between husbands and Wives, and alcohol problems (Martinez-Brawley and Blundall, 1989).

Rural Women and Substance Use Problems

Although the use and abuse of alcohol and other drugs by women has been recognized as an important health issue in Canada, specific data on use by women living in rural settings is scant. Generally, although the rates of alcohol and illegal drug use are higher among males, females are more frequent users of prescribed psychoactive drugs (Blume, 1994). Overall, while 3% of females use illicit drugs compared to 8% of males, 24% of females use illicit drugs such as tranquilizers, antidepressants, diet pills, codeine and sleeping pills (Canada's Health Promotion Survey, 1990 in *Canadian Profile*, 1995). Some 28% of women are current smokers, and, for the first time, more adolescent females are smoking than adolescent males (26% versus 19%) (*Canadian Profile*, 1995). According to the 1993 General Social Survey, 68% of women aged 15 and older are current drinkers (*Canadian Profile*, 1995).

Each year Canadian hospitals treat women for an average of 11,000 alcohol-related problems. While the data does not show that community size is related to levels of drinking, respondents (both genders combined) who live in rural areas are more likely to report a problem related to their drinking (11% compared to 8% among those living in cities of one million or more). Women, especially those with low incomes, are more likely than men to report a family or marriage problem resulting from someone else's drinking. Rural residents are somewhat less likely to report problems with someone else's drinking overall, but when they do experience difficulties, the problem seems to be more severe. Rural residents (data deals with both genders combined) are also more likely than city dwellers to drive after drinking. As is the case in all communities, women who are current or former drinkers are also more likely to smoke (*Canadian Profile*, 1995).

Rural women who have alcohol problems are in difficult circumstances. The traditional reluctance of both men and women to seek help for drinking problems is often accompanied by community denial of women's alcohol problems. An alcoholic woman is a clear departure from traditional ideas about women's roles. This contrast gives rise to a battery of ill effects. One researcher who looked explicitly at rural situations suggests that the most common element among women who abuse alcohol is the presence of psychological stress, usually associated with relationship problems (Etorre, 1992). This observation matches those of other clinicians who believe that the assessment of women with substance use problems must consider traumatic life events such as sexual abuse and violence, underlying mental

health problems such as depression or anxiety and day-to-day stresses such as a lack of support for child-care.

Physiological differences mean that women are generally affected by smaller amounts of alcohol than are men. Women's patterns of drinking also tend to be more isolating. Stigmatization prompts women to drink at home alone and to hide problematic drinking. To avoid the stigma involved in using social services many women will go to great lengths to avoid using services in their home county or area (Martinez-Brawley and Blundall, 1989). Confidentiality is not easy to obtain. Indeed, a woman is quite likely to know the counsellor or service provider personally.

As a result of these stigmatizing features, women who live in rural areas may not seek help until they are in crisis. Then the appropriateness of available services, entrance restrictions and waiting lists become significant barriers to receiving help.

Since 1991, national surveys have shown that smoking has increased among women aged 15 to 24. Surveys also show that female smoking rates appear to depend more on socioeconomic status and stress factors than on whether women live in rural or urban areas. Some groups of women are more likely to smoke than others, including:

- women with lower incomes (35%);
- women with low levels of education;
- women with children and no paid employment;
- women in blue collar and pink collar occupations (38 and 34%);
- francophone women in Quebec (University of Toronto, Centre for Health Promotion, 1995).

There are clear indications that "women who face multiple forms of discrimination or oppression may be likely to use smoking as a means of coping with this added stress" (Greaves, 1989). Smoking is associated with high stress levels, therefore it can also be a symptom of an overwhelming schedule, poverty, inaccessible child-care, inequities, relationship problems, lack of support or the experience of loss.

Mortality from lung cancer in women has now surpassed breast cancer as the most common cause of cancer-related death in North America (Blume, 1994; Gomberg, 1993). In addition to their increased risk for the smoking related diseases commonly seen in men, women are vulnerable to specific risks related to reproductive health and pregnancy.

There is evidence that rural stress affects physicians' prescribing practices in rural Saskatchewan. Janzen (1994a) found higher prescription levels for central nervous system (CNS) drugs in rural areas. Janzen speculates that these higher prescription levels may be partly explained by some physicians' frustration with medical services that are inadequate for coping with the increase in rural stress. Saskatchewan Agriculture and Food reports (*Farm Facts*, 1993) that in 1987, 95% of farmers surveyed in Saskatchewan felt that satisfaction with farm life had worsened in the last five years.

The situation in Saskatchewan is common across Canada. Women are more likely than men to experience the stresses associated with multiple roles and violence as well as life condition stresses such as poverty and isolation because they are more likely to be in positions of disempowerment. Higher levels of depression are reported in women with little personal support, little or no help with child-rearing and few financial resources (Janzen, 1994b).

Despite the above generalizations, it is important to stress that rural women are not a homogeneous group. Rural women with substance use problems may vary greatly in terms of age, socioeconomic status and other demographic factors. More gender-specific information on women who live in rural areas is surely needed.

III.
Program and Service Issues

Lack of Services

The lack of appropriate services for women in rural areas is a major barrier. The problems range from a lack of the service itself (Bois, 1989) to services that are understaffed and undersupplied. Appropriate specialists may not be available or may be too costly. For many service providers, there is a limited range of referral options.

There may be no women-centred services or programs that reflect current research on women in the substance use field. Many treatment programs are still based on a male model of substance use patterns. Assessment procedures are also sadly out of date and limited for women. Assessment often does not reveal health problems that a woman may have as a result of substance abuse. Many patterns of women's use are not identified by assessment; often no tools, treatment or interventions are offered that pertain to women's lives, much less rural women's lives.

By far the most accessible self-help group in rural areas is Alcoholics Anonymous (A.A.). The focus in A.A. is on sobriety only. Other issues affecting women's health and substance use are not discussed.

Inadequate treatment and counselling for physical and sexual abuse, especially for women abused as children, is a large problem. The main users of all sexual assault phone lines are women seeking help for the abuse they suffered as children, not as women in crisis dealing with a current sexual assault.

Rural Health Professionals

Service providers may have little knowledge about rural women. Urban professionals who spend short times or apprenticeships in rural areas are not familiar with rural life and its problems. People with problems want to talk to their peers, not to an out-of-touch stranger. Rural women are not unique in this desire. One of the first questions that many farm stress lines hear is, "Am I speaking to another farmer?" Finding empathic, knowledgeable support can be difficult for a rural woman with substance use problems. Sometimes, health professionals are addicted themselves. Difficulties with confidentiality and the need to travel long distances for support are significant barriers for health professionals in this situation.

Health Promotion

There are several barriers to the development of health promotion programs specific to substance use and rural women. Awareness of women's substance use problems is low. Denial is high, and community mores often militate against discussion of the issues. Distance and small numbers make it difficult to meet face-to-face for education and advocacy activities. There is a lack of service providers who are knowledgeable and sympathetic to the rural problems, and there is little resource material or educational programming in the substance use area with a rural focus.

Awareness, education and the need for action must be built on a community-by-community basis. Substance use problems (including smoking) must be seen as a public health problem. Awareness is the first step. Then, individual communities need to find ways to respond and prevent problems by addressing the social factors that precipitate substance use problems, such as family violence, isolation, discrimination and inequity. Women-centred, health promotion programs designed to increase empowerment and self-esteem among rural

women in general would be helpful. Intervention strategies need to address the underlying conditions that lead to substance use problems, not just the addiction itself.

Child-care Services

The unavailability of child-care is also a rural issue. Forty-six per cent of farm women work off-farm (Berntson, 1993). Even for women with no paid employment off-farm, the need for child-care can be seasonal. When farm production is at its peak, most women are busy in farming activities. Relatives and neighbours may not be available for child-care. Some rural families take children into the work situation, which can be risky for children and parents. Parents can neither give full attention to supervising their children nor concentrate totally on the farm work. Some families reluctantly leave children unattended at home due to the scarcity of local child-care options. The average distance from 50% of farms in Canada to the nearest child-care is 15 kilometres.

IV.
Learning From Program Examples

Why These Programs Were Selected

This section describes selected programs in substance use and other related areas that provide insight into effective programming in rural areas. Examples have been chosen that demonstrate several of the following principles of good programming suggested by the literature review and discussions with key informants:

- Use an empowering, woman-centred health promotion approach.
- Address the stigma and shame that are often associated with substance abuse and maintain confidentiality at all costs.
- Include stress reduction techniques.
- Include clients in planning, evaluation and recruitment. First contacts should be rural women to rural women.
- Ground programs in the reality of rural women's lives. Address community norms and make links with community resources.
- Ensure that resource materials have a rural context and are appropriate to the education level of participants.
- Address transportation and child-care needs.
- Offer flexible programming to accommodate different people's time commitments.
- Encourage social support networks and groups in a variety of forms.
- Provide training to local women so they can serve as resource people.
- Collect accurate data on issues and needs and evaluate programs.

A description of each program follows. The comments section of each addresses the major implications or learnings for the development of future programs on substance use and abuse with rural women

Program Descriptions

1. The Farm Business Health Model

Audience: Farm businesses

Strategy: Health promotion

Source: Work and Education Health Promotion Unit
Health Promotion and Programs Branch
Health Canada, 6th Floor
Jeanne Mance Building
Tunney's Pasture
Ottawa, ON K1A 1B4
Tel (613) 954-8857
Fax (613) 990-7097

Description: Health Canada has devised a comprehensive program called the Workplace Health System. One of its components is the Farm Business Health Model, which can be tailored to suit any farming district in Canada. Farm business refers to people who actively farm the land to produce food.

The process starts when an individual, a farm group or a group of health service providers contacts others that might be interested in participating. One group agrees to act as coordinating agency, and a farm business health committee is formed. There are seven steps in the farm business health model: orientation, getting organized, a needs assessment, the workplace health profile, creating a farm business health plan (two to three years), creating a program action plan (annual) and reviewing progress.

The needs assessment includes 37 questions dealing with health-related attitudes and practices and it can be customized by adding extra questions. Participants are surveyed about their attitudes in three areas: their environment or surroundings, their sense of control over their health in work situations and their health practices. The questionnaires are analyzed by an outside firm and confidentiality is preserved.

The coordinating agency receives a comprehensive workplace health profile based on the survey. The profile contains a general report and up to seven special reports (stress, health and safety concerns, physical activity, weight, smoking, alcohol and medication use). The profile provides a tool for identifying the unproductive stress factors in the farm business. Programming is then developed to address these sources of stress. The coordinating agency, the farm business health committee and the district then draw up an effective long-term strategy for addressing the issues. Partnerships, resource sharing and linking with local agencies are stressed.

A yearly action plan is devised from the health plan. As a final step, Health Canada provides evaluation tools and guidelines to review progress. The cost of the program depends entirely on how much those involved in the model think is affordable.

Comment: This model provides an effective way to define and approach rural health problems. Outstanding features of the model include the central role played by public health nurses who can be found in all rural areas, and the technical support provided to groups who participate. However, the needs assessment survey does not include a special section on rural women's health concerns.

The Farm Business Health Model provides a useful way for rural women's groups to introduce their health priorities into the community. It provides a community-based mechanism for the assessment of health needs, and a plan and commitment to address those needs. The challenge will be to use the farm business health model as a tool to promote the specific health needs of women.

2. *Empowering Rural Families and Communities. Five Programs*

Audience: Rural families

Strategy: Varied

Source: Hughes, Robert Jr. (1987). Family Relations, 36, 396.

Description: The author describes four programs for rural families and communities in the United States. Empowerment was the unifying factor in all of the programs. The programs used clinical, educational, self-help and advocacy strategies according to the particular orientation of the implementing organization. Techniques of service delivery were specifically designed to meet the needs of rural families.

i. **Rural Route**, which was sponsored by the University of Illinois Cooperative Extension Program, was designed to help rural families facing transitions due to financial problems. The program included a toll-free telephone service to extension professors who were familiar with financial and family issues, group meetings and referrals to appropriate services. The program was not limited to families in crisis, thereby eliminating the stigma attached to help-seeking behaviours, and allowed families to remain anonymous if they wished.

ii. **Beyond the Sale** is the title of a video of one farm family's experience of losing their farm. Community members are provided with a brief description of several types of support activities after viewing the video. These activities include neighbouring, support groups and peer listeners. Participants then brainstorm what type of support system might be developed in their community. The program encourages the inclusion of clergy, social service providers and other community groups that may be able to respond to rural families in crisis.

iii. **Rural Caring** was initiated by farmers for farmers in response to neighbours in crisis. Program volunteers trained in basic listening skills are available on a telephone hotline. They listen, help with problems, make referrals and answer questions about assistance programs available to farmers. The volunteers were trained by clergy, counsellors, a university extension division, the farm bureau, a hospital and a community mental health agency. The program is embedded in the community and reflects diverse local values.

iv. **Church-Based child-care** was one community's way of responding to the growing numbers of rural women who work off the farm or outside the home and to the increasing number of older adults in rural communities. The church provided the space for a day-care centre and subsidized the utility costs so that care could be provided to rural families at a moderate fee. In doing so, the church had the ability to set aside traditional values that label women primarily as homemakers and caregivers.

Comment: Though these program descriptions are fairly brief, they reinforce the principle that rural women must be included in all parts of program development. Communities differ in local norms and customs, and the only people able to devise truly effective programming are those who are part of the community itself. The program descriptions also demonstrate specific strategies that address the needs of rural women such as toll-free phone lines, church-based childcare, volunteer training, interorganizational cooperation, home visiting and family clustering. The programs engage women at the level of neighbourhood and family groups. These small networks are already in place, and transportation problems are minimal.

3. *The British Columbia Day, Evening and Weekend (DEW) Pilot Program for Women*

Audience: Rural women

Strategy: Treatment, relapse

Source: Adult Clinical and Addictions Services Branch
British Columbia Ministry of Health
3rd Floor, 1810 Blanshard Street
Victoria, BC
V8T 4J1
Tel (604) 952-0800
Fax (604) 952-0808

Description: the needs of adult women living in rural situations who had achieved recent sobriety from alcohol and other drugs but remained at serious risk of relapse. The program consisted of 10 days of intensive treatment designed specifically for the recovery needs of women. It was delivered in seven different communities in British Columbia from September 1993 to March 1994. The short-term outcome objectives of the DEW program were:

- continued abstinence from substances;
- improved confidence and coping ability in high-risk situations;
- increased self-esteem;
- decreased depression;
- increased internal locus of control;
- enhanced awareness of recovery issues;
- continued outpatient contact postdischarge.

Many of the women who entered the DEW program shared family histories of substance abuse, and many reported emotional, sexual or physical abuse during childhood. In adult life, economic hardship and unemployment were common experiences. Seven out of 10 women received some form of social assistance and half had one or more children. After treatment, clients were less depressed and showed higher levels of self-esteem. They were also more confident at

discharge that they could maintain abstinence in high-risk situations. After completing the program, participants were more likely to believe that they had control over events in their lives.

Comment: The DEW program is unique in its role as a women-centred relapse treatment program for chemically dependent women who live in rural areas. DEW can be offered in flexible formats and has mobile staff that can respond to geographic and transportation needs. The program is empowering to rural women. Childcare is offered and transportation to rural locations is addressed by subsidizing costs and by car pooling.

4. *Host Homes*

Audience: Women

Strategy: Intervention, treatment

Source: Adult Clinical and Addictions Services Branch
Community Health Division
British Columbia Ministry of Health
3rd Floor, 1810 Blanshard Street
Victoria, BC
V8T 4J1
Tel (604) 952-0804
Fax (604) 952-0808

Description: To expand the number of choices of residential treatment options and to enable people to remain in their own communities as much as possible, the British Columbia Ministry of Health developed the Host Homes model of residential support. A Host Home provides a safe and supportive living situation for a person who needs a temporary residence while receiving treatment at an alcohol and drug services (ADS) outpatient program. Host Homes are provided by private citizens. Host Home providers receive training, a small per-diem fee to cover costs and ongoing support from ADS staff.

Residential support in a Host Home setting provides for the basic needs of the individual as well as offering a modicum of emotional support, assistance in attending appointments (counselling, medical, dental, etc.) and encouragement to use the self-help network. The Host Home provides an environment that facilitates the counselling process elsewhere (usually the nearest ADS outpatient facility) and may include opportunities to learn life skills and engage in supportive discussion with others, as well.

Comment: Host Homes could be used by rural women when treatment services are unavailable locally or when there are concerns about confidentiality. Some Host Homes can also accommodate a parent with a child. Host Homes provide a valuable option for young rural mothers or adolescent women who require outpatient treatment that is available only on a regional basis.

5. *Women Reaching Women (WRW)*

Audience: Women

Strategy: Prevention, intervention

Source: Project Director
Women Reaching Women
310 East Broadway
Monona, WI 53716, USA
Tel (608) 223-3355
Fax (608) 223-3365

Description: WRW is a state-wide, community based project of the Wisconsin Association of Alcohol and Other Drug Abuse, a volunteer organization with local chapters that allow women to collectively and locally decide the kind of activities they can undertake to improve services for women who are adversely affected by alcohol or drug use. The goals of the program are to increase public awareness of the impact of alcohol and drugs on women throughout their lifespan, to promote healthy lifestyles for women, to assist women in their recovery, to advocate the needs of women and to train and use volunteers to achieve these goals.

The WRW organization provides technical assistance to chapters at all stages of development. Basic activities are integrated into the planning of every local branch: public awareness

campaigns, needs assessments, networking, advocacy, influencing public policy and fulfilling responsibilities to the WRW state office. Previous projects undertaken by WRW include facilitating support groups for children of alcoholics and establishing Women for Sobriety and other women-only groups. Community outreach and educational awareness campaigns have focused on fetal alcohol syndrome (FAS) and the needs of women in treatment. Many chapters provide child-care for women in support groups. The WRW model stresses the establishment of interdependent and cooperative relationships. WRW relies on local resources and local determination of needs and responses.

There is extensive literature on the formation of WRW and its programs, including a *Volunteer Guide to Chapter Development.* WRW tackles chemical dependency, sex-role differences, smoking during pregnancy, FAS, sexual assault while under the influence, wife abuse and other issues in a women-centred, empowering way.

WRW fills many gaps in the service structure for women with substance use problems including support to attend treatment, after-care and maintenance activities, child-care, transportation, support for families with FAS children and others. The broad focus of WRW encourages links among groups dealing with women's issues.

Comment: WRW is a cross between a large self-help network and a state-funded grassroots program. It is effective and has a high benefit: low cost ratio. Its success is confirmed by several measures, including continued funding, increased support from its sponsoring agency and board, growing membership, increasing acceptance from Alcoholics Anonymous and other groups, requests for presentations on the program and the growing dedication of its leadership and members. WRW appears to be one of the most effective models for supporting women with substance use problems in rural areas. Liaison with this Wisconsin state-supported program could lead to the creation of an effective North American network.

6. *Violence Against Women and Substance Abuse: A Public Service Announcement (PSA) for Rural Women*

Audience: Women using substances who are being abused, Renfrew County

Strategy: Information, education

Source: Julia Greenbaum
Addiction Research Foundation
33 Russell Street
4th Floor Tower
Toronto, ON M5S 351
Tel (416) 595-6901
Fax (416) 595-6923

Description: The Addiction Research Foundation, in partnership with the Women and Substance Abuse Subcommittee of the Renfrew County Committee for Abused Women, is currently developing a television PSA to raise awareness among women who are being abused by their partners and who may be using alcohol or drugs to cope with the abuse. The PSA's message is that drug or alcohol use may compound the problem and that there are other ways to address the situation. The 30-second PSA will be shown in both rural and nonrural communities.

Family violence surveys done by Statistics Canada show that substance use problems are highest among people who have a history of physical, mental and sexual abuse. Many women use drugs to deal with childhood or adult abuse, but they seldom see the link between the two. The PSA highlights this connection in a short vignette and then presents an alternative: Get help. No specific local telephone number is given, because women may not feel safe taking it down (i.e., if their partner is around) and because there are many different local numbers. The announcement does provide a 1-800 number for the Drug and Alcohol Registry and urges women to "call your local women's abuse help line."

The vignette takes place in a typical modest rural kitchen, with which most women in the target audience could identify. The viewer is encouraged to use the phone book when her partner is not around to find a local agency that deals with abuse.

Comment: Only time will tell how effective the PSA will be in reaching rural women. Certainly there are a number of elements to this program that appear to address the issues of isolation and distance and, more importantly, the link between abuse and substance abuse. According to the Addiction Research Foundation, understanding this link is essential to successful treatment and recovery.

The use of television as a means of reaching isolated women could be very powerful. Most rural homes have a television and there is a very real possibility that some men may also make the link between domestic violence and substance use problems as a result of watching the PSA.

7. *Femmes et Elixirs*

Audience: Women

Strategy: Prevention, intervention, treatment

Source: Guédon, Marie-Chantal and Mercier, Céline. (1994). Sherbrooke, Quebec
Elixir ou l'Assuétude d'Eve Inc.
111, rue King, piéce 201
Sherbroke (Québec) J1H 1P5
Tel (819) 562-5771

Description: Femmes et Elixir, a substance use program for women aged 20 to 59, ran for 10 years in the rural areas in and around Sherbrooke, Québec. The program included 10 weeks of three-hour sessions with about 10 women in each group. Objectives of the program were to build support networks for women who were experiencing problems with substance use, to educate women on the consequences of using alcohol and other drugs, to empower women to make alternative choices, to improve health habits, to improve mental health and to assist women in communicating with health professionals.

Each meeting consisted of homework, reflection, check-in, relaxation, a thematic activity, plans for the week and an introduction to the next weeks topic. Group techniques included role playing, cognitive restructuring, drama and relaxation. Weekly contracts were made with each participant as a way to monitor their progress.

A thorough evaluation of the Elixir program revealed that attrition was high among young women; however, the program was effective with older women. They demonstrated increased self-esteem and a better understanding and acceptance of alternatives to drug use. The young women were less receptive to the cognitive methods and overtly feminist approach used in the program. There was also criticism of the length of the program, the assessment procedures and the lack of group rapport. The latter problem occurred because the program attempted to combine prevention, intervention and treatment. The participants reflected this mix.

Comment: The evaluation of the Elixir program and subsequent decision to give the program a face lift to adapt to the context of the '90s speak to the importance of ensuring that programs remain reflective of women's life experiences as times change.

8. *Nova Scotia Department of health, Drug Dependency Services*

Audience: Women with drug dependency in northern Nova Scotia

Strategy: Information, education, intervention

Source: Nova Scotia Department of Health
Drug Dependency Services:
Northern Region
P.O. Box 359
Pictou, NS B0K 1H0
Tel (902) 485-4335
Fax (902) 485-7026

Description: The Drug Dependency Services (DDS) unit of the Nova Scotia Department of Health operates four outpatient offices in three counties to serve both men and women with drug dependency. Each office is staffed by at least one clinical therapist (psychologist or social worker) and a number of community health workers. The latter are usually people with a minimum of five years successful recovery who have been trained in addictions counselling. Most have a community college certificate or other advanced schooling and some are enrolled in a university-based program in social work. All community health workers receive ongoing training both on-the-job and through regularly scheduled training events.

Female community health workers have become a major rural resource. Because they are often the main liaison with local self help groups, they have numerous opportunities to speak with rural women. Because they live in the community, they are able to go into the homes of isolated women and to run evening programs.

Rural women face unique challenges in receiving both inpatient and outpatient services. Although the number of women who can get into detox is increasing (now 20%), rural women are generally more likely to use outpatient services. Mixed gender treatment programs can prove intimidating for women, as they are far outnumbered by men. DDS has developed an all-women treatment orientation program for both inpatient and outpatient services that includes components on self-esteem and assertiveness. The challenge is to gather enough women together to run the program. This calls for a lot of flexibility in program design and delivery.

DDS uses any opportunity to talk with schools, colleges, church groups, women's institutes, women's agencies, health agencies and physicians. They often go into women's shelters and do sessions on issues such as addiction to pills or gambling. They partner with a variety of women's groups and other county service agencies (e.g., family violence, mental health, the courts, probation services).

DDS is currently struggling with the problem of program evaluation. Although they see successful outcomes with women who attend their programs, the evaluation documentation to date has been activity-based only.

Comment: The effectiveness of using trained, local women who have had personal experience with substance use problems is a highlight of this program. The facilitators live in local communities and provide comprehensive outreach services. They take every opportunity to talk to and partner with community groups to expand their sphere of influence.

DDS supports the need for women-only programs even when small numbers make it difficult to put into place. They also recognize the need to link substance use problems with low self-esteem and violence in the home, and to provide flexibility, both in their staff makeup and in the design and implementation of programs.

9. Town Youth Participation Strategy

Audience: At-risk youth in small communities

Strategy: Prevention, intervention, education

Source: Executive Director
TriCounty Addictions Program
1 1/2 Russell St. West, 2nd Floor
Smiths Falls, ON K7A 1N8
Tel (613) 283-7723
Fax (613) 283-9407

Description: the Town Youth Participation Strategy (TYPS) began as a pilot program in 1993. TYPS's goal is to facilitate program development in small communities that will allow at-risk youth to become more involved in their community and to have more of a voice in decision-making.

TYPS staff often make presentations on youth issues and on the benefits of youth centres, particularly as they apply to small communities in Eastern Ontario. They are also supportive of and affiliated with youth-focused organizations such as Alwood (an addictions recovery home for youth),

Operation Go-Home, the Salvation Army Hostel in Ottawa, and a new joint committee concerned with drugs and alcohol within local schools. The Centre for the Study of Training, Investment, and Economic Restructuring is also working with TYPS to develop a computerized program for youth centres.

Before the inception of the TYPS Project, a proposal was forwarded to community leaders, social services and youth organizations in each community within the region, and they were asked if they were interested in becoming involved in the project. Workshops designed to gather information and encourage networking were then set up in the communities that responded. Almonte, Brockville, Kemptville, Perth, Prescott and Smiths Falls were selected to participate in the program, but 10 other communities are also involved at different levels.

Initially, a facilitator goes into the community and works with youth and adults to set up youth groups, youth centres and youth advisory councils. Once the centres have been established, they are managed by a part-time staff person and about 20 volunteers. Adults in the community act as role models and provide advice and assistance. Representatives from local service organizations often drop in to the centres, generating informal connections and links. The success of these initiatives depends largely on overall community support and the presence of a champion of the cause within the community.

A wide range of young people (females and males) participate in the programs, but often it is those who are at risk who continue to be involved. Many of these young people use the centre as a temporary haven from abusive or neglectful home environments.

Transportation to a centre is a major challenge for youth in small communities. As a result, meetings are typically scheduled after school or on Friday nights when young people can arrange to get a lift into town.

Comment: TYPS is an effective model for engaging marginalized youth in developing their own community programs. It demonstrates a number of factors that are critical to program success. Chief among these is a community champion and community support and endorsement, both in developing and in sustaining the program. A circular relationship develops in towns where there is strong community support. As youth prove themselves, the town provides additional support and public recognition, which then encourages young people to work even harder toward their goals.

Another critical component is the establishment of a youth advisory council. TYPS provides the spark, information, networking opportunity and coaching necessary to establish a program, but young people themselves drive the program. content and delivery.

A secondary benefit of this program may lie in changing the community's perception of youth. As adults begin to support and understand the dynamics of youth-at-risk, their tolerance for and acknowledgement of young people increases. This, in turn, leads to improved behaviour and enhanced feelings of self-esteem in young people.

10. Fear on the Farm

Audience: Rural women dealing with family violence

Strategy: Prevention

Source: Canadian Farm Women's Network and Birdsong Communications Ltd.,
Saskatoon, SK
88 Crown Avenue
Fredericton, NB E3C 1C9
Tel (506) 450-3710
Fax (506) 458-8251

Description: Fear on the Farm is a study guide and video about farm family violence. The guide has five separate formats that can be used with the video. They range from a one-hour follow-up discussion to a two-day workshop and the use of study circles. The package is designed to help each community define the problem and its

response, yet the connections between the local community and larger society are clear.

Comment: Fear on the Farm is an example of community prevention programming that is particularly appropriate in rural communities. The flexible formats described in the guide make the program useful in a variety of settings and with a variety of groups. Since problematic substance use is often part of family violence situations, *Fear on the Farm* can be used to develop action around both issues at the same time.

11. LESA: A Program of Lifestyle Enrichement for Senior Adults With Alcohol and Other Psychoactive Drug Problems

Audience: Adults 55-plus years of age

Strategy: Intervention

Source: Centretown Community Health Centre
340 MacLaren Street
Ottawa, ON K2P 0M6
Tel (613) 563-4799

Description: LESA is designed for adults over age 55 who live independently in the community and who are experiencing problems with their use of alcohol and/or other psychoactive drugs. The program includes individual counselling and group activities (e.g., mutual support groups, recreational activities). The age-specific approach means that both assessment and treatment is geared to the pace and readiness of each client to make changes in her life. Women and men meet separately in mutual support groups, but come together for lunch and recreational activities. Though the LESA program was developed in an urban setting, the approach has been adopted and used in a number of communities (rural and urban) across Canada.

A program manual is available from Centretown Community Health Centre at a cost of $15. Evaluation of the program model is described in *Addictions Treatment for Older Adults: Evaluation of an Innovative Client-Centred Approach* by Kathryn Graham, Sarah J. Saunders, Margaret C. Flower, et al., Haworth Press, New York, 1995.

Comment: The LESA program and other similar ones (e.g., the COPA program in Toronto) share several important characteristics: They provide

- individual outreach to the client's home, where most of the counselling takes place
- an approach that does not require abstinence as an admission requirement
- a focus on the substance itself, reasons for use and the harm caused by use
- a holistic approach to helping an older person in a way best suited to her needs
- a flexible time frame and a supportive, nonconfrontational approach.

12. Stop Smoking Programme for Women on Low-Income

Audience: Women with low incomes

Strategy: Smoking reduction and cessation

Source: Canadian Public Health Association
1565 Carling Avenue
Ottawa, ON K1Z 8R1
Tel (613) 725-3769
Fax (613) 725-9826

Description: This program was developed in 1990 to address the specific needs and challenges of low-income women who want to reduce or quit smoking. The Stop Smoking Programme for Women on Low-income has been delivered in every province except Newfoundland and British Columbia. Although designed for low-income women, the program is open to all.

The program uses a holistic, woman-centred approach to address smoking reduction and cessation. It is based on behaviour change theory and consists of various sessions led by a trained facilitator. The format is flexible, with participants setting the agenda for meetings and identifying the subject areas to be discussed.

Group sessions are held in accessible, non-threatening community locations. Transportation and child-care are provided free if needed.

Potential participants are visited at home and asked to complete an intake questionnaire. The first component of the program consists of four two-hour group sessions to raise awareness about reasons for smoking. These are followed by six to eight sessions dealing with goal-setting, withdrawal and the benefits of not smoking. Enhancing self-esteem and fostering group support is a key aspect of this phase. Five follow-up sessions provide support in the first six months after quitting.

Six months after quit date, 25% of participants had quit smoking (self-reported). Others reported smoking reduction and other benefits such as increased confidence and an enhanced sense of control in their lives.

Comment: The program is community-based and is flexible enough to accommodate local and group needs. Important factors are addressed including child-care and transportation needs, stress management skills, follow-up support and the training of local people to address the specific needs of rural women. The program can be used by a wide range of community groups in churches, schools and other community settings. The program is currently undergoing revisions and the new program will be available in the fall of 1996.

13. Nova Scotia Heart Health Social Marketing Campaign

Audience: Nova Scotian women aged 18 to 24 with low socioeconomic status

Strategy: Smoking cessation

Source: Nova Scotia Heart Health
5849 University Avenue
Halifax, NS B3H 4H7
Tel (902) 494-1919
Fax (902) 494-1916

Description: For eight weeks, radio and television messages were broadcast across Nova Scotia, offering help and a 1-800 number to women who wished to quit smoking. A range of cessation assistance was offered, including a self-help manual and referrals to physicians, nurses, pharmacists and counsellors in the community. Women were also referred to group cessation programs based on the Stop Smoking Programme for Women on Low-Income, if one was available in their community. The Nova Scotia Lung Association received the 1-800 calls and made appropriate referrals.

Comment: This project demonstrates how the media can be effectively used when combined with local resources to reach women in isolated areas. The use of a 1-800 number gives everyone access to help or referrals.

14. Oui, J'arrête! - Yes, I Quit!

Audience: Women with low incomes and low literacy skills

Strategy: Cessation

Source: Direction de la Santé Publique,
Régie Régionale de Montréal Centre
4835, rue Christophe-Colomb
Montréal (Québec) H2J 3G8
Tel (514) 932-3055
Fax (514) 932-1502

Description: The Oui, J'arrête self-help guides and workshops were developed in 1993 to address the specific needs of socially disadvantaged women in Montréal. The program is based on behaviour change theory and consists of six workshops, each two hours in length. A trained facilitator leads participants in discussions related to why women smoke, preparing for quitting, coping with quitting and how to remain a nonsmoker. The self-help guide is easy to read and largely pictorial. It uses humour and illustrations to convey quitting strategies.

Workshops are held in non-threatening places such as community centres. The program continues to be delivered in Montréal and other areas across the eastern provinces. Workshops were evaluated from 1989 to 1991. Three community groups from the Montréal area were

offered free registration in 10 series of workshops. Sixty-six of the 91 participants were women. Results showed cessation rates of 29% at two weeks and 25% six months after the final workshop.

Comment: The program is flexible and useful to rural groups that need a smoking cessation program for women with low literacy skills.

15. Women and Smoking

Audience: Women in lower socioeconomic groups

Strategy: Reduction and cessation

Source: Action on Women's Addictions—Research and Education (AWARE)
P.O. Box 86
Kingston, ON K7L 4V6
Tel 613) 545-0117
Fax (613) 545-1508

Description: The Women and Smoking self-help support group and manual were developed in 1994 to address the specific needs of low-income women and sole-support mothers. The program takes a women-centred approach and uses stages of change theory to examine the issues relating to tobacco reduction and cessation.

The self-help manual explores smoking as a women's issue with particular emphasis on why women smoke and what strategies can be used to facilitate quitting. In the pilot test, a self-help support group was provided. Participants met with a facilitator six to eight times for one to two hours each time. Participants set the agenda and the focus was on discussing women's experiences, not smoking cessation. Child-care was provided.

Follow-up data at the completion of the group sessions showed a significant decrease in smoking among the self-help support group participants and no reduction in cigarette consumption among those who used the manual alone. At four months, the support group decreased consumption to 50% of baseline levels. The manual only group had mixed results.

Comment: The self-help manual is available from AWARE. Other tobacco cessation self-help manuals are available from the Lung Association and other sources. Self-help manuals are particularly useful in rural settings where it is difficult to get women together in groups. This project, however, demonstrates how the addition of a self-help group (in person or by telephone or computer) can aid tobacco reduction and cessation.

16. LIB-AIR-TE

Audience: Young francophone women from lower socioeconomic backgrounds

Strategy: Prevention, cessation

Source: Eastern Ontario Health Unit
1000 Pitt Street
Cornwall, ON K6J 5T1
Tel (613) 933-1375
Fax (613) 933-7930

Description: LIB-AIR-TE was developed in 1989 to address survey findings that 54% of francophone women aged 20 to 40 in small towns in Eastern Ontario were smoking. The project consisted of two parts: a prevention component, and a cessation component, The cessation component involved a computer-assisted smoking treatment approach together with eight one-hour group sessions. The program was delivered in workplaces, community centres and women's centres. At six months follow-up, 23% of participants remained smoke-free. Those women who did not quit reported reducing their smoking levels from a mean of 23 cigarettes a day to 5 by the end of the program.

Comment: LIB-AIR-TE demonstrates the opportunity of using the workplace in small towns for programming and provides a francophone specific experience with tobacco reduction and cessation.

17. Born Free Smoking Cessation for Pregnant Women

Audience: Pregnant women who smoke

Strategy: Smoking cessation

Source: Prince Edward Island Department of Health and Community Services
P.O. Box 2000
Charlottetown, PEI C1A 7N8
Tel (902) 368-6130
Fax (902) 368-6136

Description: Born Free is a package distributed by the Prince Edward Island Department of Health and Community Services to all public health offices across the island. Public health nurses who see pregnant women on a routine basis deliver the program. The 10-day self-help quit program is explained by the nurse, who also provides follow-up support by telephone. Where possible, a quitting contract is signed by the participant and a buddy whose role is to provide support. Of the 105 women who were introduced to Born Free between 1991 and 1993, 24 quit and 39 cut down in smoking. In 1994, professionals using the program had mixed reactions to its effectiveness.

Comment: Since Prince Edward Island is largely composed of rural communities, this program model—which makes use of public health nurses to assist with smoking cessation—may be applicable in other rural areas. The concept of a "quit buddy" support person may also be a useful idea.

18. Rural Tobacco Study

Audience: Dental patients who smoke

Strategy: Information, education, cessation

Source: Cancer Prevention Program
Alberta Cancer Prevention Board
1331 - 29th Street N.W.
Calgary, AB T2N 4N2
Tel (403) 670-4862
Fax (403) 270-8003

Description: The Rural Tobacco Study (RTS), a three-year program of the National Cancer Institute of Canada, is developing a pilot education program for dental practitioners in rural areas that will allow them to counsel patients about dental problems associated with smoking. The RTS is working closely with the dental community (dentists, hygienists and dental assistants) to provide a simple, inexpensive, easy-to-use educational program that dental offices will feel they can use without jeopardizing their relationship with their patients. The program is based on cessation research that says health professionals can be successful at getting patients to quit smoking by asking them about their current tobacco use and attitudes to quitting and by providing simple advice based on the client's current stage of preparation for quitting. The package will be mailed to all rural dental offices in Alberta. Mailed programs in both the dental and tobacco counselling fields have been shown to be effective in Australia.

The program is positive in tone. It emphasizes the fact that most people eventually quit on their own and that the best strategy is to build on small successes. It will stress the benefits of quitting and try to motivate people to move to the next stage or quit. There will be a section that deals with why tobacco is a dental problem and why patients should be concerned, a section on the oral health problems caused by tobacco use, a section on addiction and understanding the smoker, and a section on counselling, including how to give advice on quitting if the patient is interested. The oral effects of smoking are very obvious but regress immediately when people stop smoking. Therefore, there are many built-in rewards for both the patient and the dental profession.

The educational material is based on existing resources. During the pilot, the expert panel will act as consultants to the dentist. Once the training program has been mailed, they will call the dental office and offer support and encouragement. After the pilot evaluations have been completed, the dentists will be given feedback by the project team and coached on how to improve.

Comment: Currently, there are few smoking cessation support programs in rural Alberta. The RTS uses an innovative yet practical approach to reach isolated women who receive dental care. It is fact-based and non-threatening. It deals with symptoms that are immediate and visible, as opposed to the invisible, long-term consequences of tobacco use on physical health. Patients are reassured that most people give up smoking on their own after five or six attempts. The emphasis is on dental health not lung cancer.

Dental practitioners are rarely considered front-line workers in tobacco cessation. The RTS demonstrates the effectiveness of reaching out to allied health and social service professionals who have access to a rural clientele. The RTS also stresses the importance of involving the target' audience in the design and development of programs they are to deliver. The use of an expert panel of dental professionals ensures that the program will meet the needs of the dental community. The RTS also demonstrates the benefits of using existing resources (i.e., cessation training materials) and tailoring them to dental practitioners. This reduces the cost of developing and maintaining the training package.

19. Telelink

Audience: HIV-positive women in Ontario

Strategy: Information, education

Source: AIDS Committee of Cambridge
Kitchener, Waterloo and Area
123 Duke Street East
Kitchener, ON N2H 1A4
Tel (519) 570-3687
Fax (519) 570-4034

Description: Through teleconferencing, Telelink brings together HIV-positive women living in rural communities in Ontario every second Sunday from 8:00 to 10:00 p.m. The goals of the two year-old program are to build a sense of community between isolated women who are HIV positive, to facilitate the establishment of a peer support network that may extend beyond the teleconference call, to provide support and education, and to develop a model for use in other urban or rural communities.

About 25 women have registered with Telelink, most having been referred by public health departments or local AIDS committees. Approximately 6 to 12 women participate in each call. They are asked to check in and out of the call, but active participation during the discussion is a personal decision. Calls are open-ended. Each group determines what they wish to discuss, based on issues of personal relevancy.

Three factors have been identified as critical to the success of the program: confidentiality, privacy and the security of a judgement-free, safe place. The requirements for confidentiality and privacy are addressed by scheduling the phone calls in the evening when children are in bed, by using the women's first names for the operator-assisted teleconference calls and by mailing out monthly newsletters wrapped in plain brown envelopes.

It is the facilitator's responsibility to create a safe environment for participants. To do this, she must have knowledge about HIV, interest and knowledge in gender-specific issues for women and understanding of isolation and family issues. Strong interpersonal skills are essential given that she can use only verbal cues without the benefit of eye-to-eye contact. To prepare for her job, the Telelink facilitator underwent a comprehensive orientation that included a literature review, education on group process and meetings with individuals and groups working with women who are HIV-positive.

Safety is ensured in several ways. Participants are not pressured to become actively engaged in the discussions and are free to drop out at any time. The agenda is driven by the women's needs, and formal and informal feedback is continuously solicited. Initially, each participant is made aware of the principles behind Telelink: confidentiality, anonymity, use of a self-help model, mutuality, respect, involvement and sharing.

Telelink promotes the program with departments of public health, local AIDS Committees and doctors' offices with brochures for distribution. Telelink also maintains close contact with Voices of Positive Women in Toronto, (VOICES), which is a women-specific agency offering education, support, support groups, advocacy work for women and a vitamin supplement mail-out.

Comment: Programs for women who have substance abuse problems and for women Who are HIV positive face similar barriers and issues. Many of the women come into Telelink with a shared history of discrimination and isolation that is both geographically and systemically imposed. Most AIDS programs use a male model for diagnosis, and it is not uncommon for women to be told by their physician that they are the first female they have diagnosed as positive for the HIV virus. This further exacerbates their sense of isolation and shame.

Telelink demonstrates the power of teleconferencing as an effective tool for bringing together isolated women living in rural communities. It also demonstrates the importance of developing a safe environment that ensures confidentiality, privacy and a non-blaming attitude.

Another positive facet of the Telelink program is the partnership with groups doing similar work (VOICES, public health units and other women's organizations). These partnerships allow Telelink to offer a comprehensive service without incurring additional expense. Telelink does recommend, however, that the budget include funds to cover such items as mailings and travel costs associated with bringing group members together or having the facilitator meet with individuals.

20. Newfoundland-Labrador Women and HIV/AIDS Project

Audience: HIV-positive women

Strategy: Information, education, prevention

Source: Newfoundland and Labrador
AIDS Committee
P.O. Box 626, Station "C"
St. John's, NF A1C 5K8
Tel (709) 579-8656
Fax (709) 579-0559

Description: The Newfoundland-Labrador Women and HIV/AIDS Project operated as a one year pilot from May 1994 to May 1995. Staffed by an executive director, one volunteer and a counsellor with a background in social work, the program delivered health promotion and prevention services for women at risk of contracting HIV and AIDS. It also offered counselling, support and advocacy for both infected and affected women.

The majority of women served by the program lived in Conception Bay North. They were young, single and lacking in both life experience and life skills. Drug and alcohol abuse played a major role in their becoming infected: It was while they were either drunk or high that they contracted HIV. One of the objectives of the program was to work on basic self-esteem, self-awareness and anger management with these women in the hope that they would become more actively involved in establishing their own support services.

The program made links with existing rehabilitation programs, women's organizations and AIDS programs and formed an advisory committee comprised of representatives from several of these organizations. They provided a 1-800 number that was originally intended for educational purposes, but was used more extensively for counselling and support. One of the main challenges for the program was ensuring that women received the appropriate medical attention once they had been diagnosed as HIV positive. They were coached on how to choose a

doctor and assess that relationship, as well as on what options were available to them. Affected women were included in this coaching because they were frequently the ones who accompanied the infected women to the medical care site and were involved in their treatment decisions.

Although there are hospitals and doctors in the Conception Bay North area, the HIV infection control doctor is located five hours away in St. John's. As a result, many of the HIV-positive women have moved to St. John's where they have better access to services and a better chance of anonymity. Unfortunately, those who have not moved remain isolated from treatment services.

A number of HIV-positive women have formed their own informal support groups. They frequently use the 1-800 number to connect with other women who are geographically removed or to discuss questions raised by the group. About 120 women are on a mailing list with the Newfoundland-Labrador Women and HIV/AIDS Project and are sent information regularly about women and HIV.

Comment: Many of the infected women perceive that dealing with HIV and AIDS is just one more issue in difficult circumstances. They are already dealing with long distances to medical centres, unemployment, poverty, family violence and low self-esteem. One of the major challenges faced by the project team was getting women to value themselves enough to seek treatment. As is often the case, the root cause of the symptoms is often a history of domestic violence and childhood abuse.

A common theme is the importance of involving infected and affected women in the development of programs designed to serve them. For example, participants did not want a facilitator who would take a feminist approach or impose a philosophy they could not understand. The facilitator did not have to be infected or be a substance abuser but had to be able to validate their experience and provide a safe environment for open and honest discussion.

21. Positive Women's Network

Audience: HIV-positive women

Strategy: Information, education, support

Source: Pacific AIDS Resource Centre
1107 Seymour Street
Vancouver, BC V6B 5S8
Tel (604) 681-2122 ext. 200
Fax (604) 893-2211

Description: The Positive Women's Network which was formed in 1989 provides a variety of support services to almost 150 HIV-positive women throughout British Columbia. The services, delivered by a staff of six, include communication (semiannual magazine and monthly newsletter), focus groups, telephone support, a women's centre, outreach programs, women's retreats and educational programs.

HIV-positive women are involved in all aspects of program planning, design, delivery and evaluation. They work hand in hand with women who are not HIV-positive to provide a balanced approach to the delivery of services. The program is run out of the Pacific AIDS Resource Centre, which has its own kitchen, living room and playroom for client's children. Nonetheless, many participants never come to the centre. Distance, the stigma attached to the disease and the location of the centre amidst predominantly male AIDS organizations are all barriers. For many of those who do visit the centre, transportation and childcare subsidies are essential. Bus tickets are provided and emergency cab fare is available for doctors visits.

The most frequently used services are telephone counselling, one-to-one outreach, advocacy and support for family and care providers. Most women contact the centre for information on AIDS shortly after being diagnosed. The staff at the Positive Women's Network are careful not to overwhelm them at first with too much information. They try simply to listen and be supportive. Normally, it takes a few months

before a woman makes regular contact and agrees to be on the mailing list. To quote one of the organizers, "They come for the information but they stay for the support."

The women's retreat program is the most successful initiative for linking women who are HIV-positive. For the last three years, the program has brought together 30 or 40 women for a few days in a small lodge on Vancouver Island. All costs are absorbed by the Positive Women's Network, including transportation and babysitting (on- or off-site). The agenda covers addiction, violence in relationships, sexuality counselling and stress reduction. The magic of the retreat, however, comes from the connections made when women are able to spend some time together away from their daily demands. Unfortunately, this is a very costly program and the centre is considering alternative methods for connecting women who are HIV-positive. One option is a telephone peer support program. Volunteers would be trained in active listening and then paired with another HIV-positive woman. A resource centre staff person would be available to provide consultation and support as required.

The goal of the program is not to duplicate existing services for women but rather to facilitate access to other community services and resources. This is accomplished by working closely with local health care providers and other service agencies. A recurring theme is the lack of information and knowledge about women and the disease. The Positive Women's Network has initiated a pilot that teams a family physician with an HIV-positive woman to educate hospital staff about women and HIV. A resource guide is being developed for doctors, and the long-term plan is to link this educational program with addiction issues. The program is also working with the faculty of nursing and the faculty of medicine at UBC to incorporate women and AIDS into the curriculum. Rural physicians are particularly interested in collaborating. They understand that HIV and AIDS are family practice conditions which they need to be prepared to treat in both male and female patients.

This year the Positive Women's Network will concentrate on youth outreach and support for younger women. In addition, the centre is seeing an increase in pregnant women who are HIV positive.

Comment: There are many elements in the Positive Women's Network program that could be incorporated into a program working with rural women in the area of substance use problems. The women are involved in all aspects of program design and delivery. Partnerships are created with numerous other service providers. Service delivery is flexible and responsive to women's needs for space and privacy. The provision of transportation and child-care services and the attempt to provide outreach services make the program accessible to otherwise isolated women. Also impressive is the work done to date on educating the medical community. Because medical practitioners are often the first line of contact for women who are HIV-positive or abusing substances, it is critical that they be informed and sensitive to the special needs of women.

22. From Dark to Light: Regaining a Caring Community

Audience: Women living in northern regions

Strategy: Education, prevention, intervention

Source: Status of Women Council of Northwest Territories
Yellowknife, NT X1A 2L9
Tel (403) 920-8938
Fax (403) 873-0285

Description: From Dark to Light: Regaining a Caring Community is a how-to package designed by the Status of Women Council of the Northwest Territories through community consultations and needs assessments. The package, which was published in 1994, is written in plain language (English, Inuktituk and French) and reflects the culture of Northern people. It is designed as a tool to be used by Northern people to foster

community awareness and conduct educational or self-help workshops.

The package includes a Facilitator's Book and six Workshop Booklets. The latter deals with issues of child sexual abuse, spousal abuse, sexual assault, parenting skills, healthy relationships and abusive men support groups. Each of the booklets contains a series of community awareness or education and prevention activities, as well as general information on the subject matter. The Facilitator's Book functions as a guide for implementing the six workshops and includes information on preparing and presenting workshops, facilitation tools, group process and selfcare. Pamphlets describing the program have been distributed to clergy, friendship centres, nursing stations, physicians, social workers, and drug and alcohol programs throughout the northern regions. This has resulted in numerous requests for assistance in setting up workshops, training sessions and self-help groups.

The Status of Women Council is working with an agency in each of the nine regions toward sponsoring training sessions with the package. From Dark to Light is based on a popular education approach that argues that the main role of the facilitator is to encourage an exchange of experiences and knowledge. In keeping with the vision of a tool that promotes community-based intervention, the facilitators of the workshops are Aboriginal women. Most, if not all, of these women have experienced abuse themselves.

Comment: This model could be effectively used by any rural community wishing to heighten awareness of issues of violence and the link to substance use and abuse. The program stresses the importance of cultural sensitivity and of involving women living in the community in the development and implementation of programs aimed at them. The package reflects the norms and culture of the women for whom it is intended. It is written in their language. The program focuses on the root causes of substance abuse rather than on the symptoms. The cost of the package is minimal (a $40 donation is recommended).

V.
Applying What We Have Learned

The literature review and key informant interviews suggested a number of principles for programming in rural areas (page 9). Combining these principles with what we learn from the program descriptions contained in the previous chapter suggest that successful programs for rural women have four key characteristics.

1. Use an empowering, woman-centred approach
2. Stress mutual aid and social support.
3. Overcome traditional barriers including isolation, a lack of services, communication difficulties and a lack of confidentiality
4. Forge links and partnerships within the community.

This section summarizes ways that programs can put these characteristics into practice.

Use an Empowering, Woman-Centred Approach

- Use a holistic, multidisciplinary health promotion approach.
- Acknowledge the links between substance use problems and other health issues including stress, family violence and HIV infection. Address the root causes of substance use problems (e.g., isolation, poverty, violence, inequities), not just the addiction itself.
- Include clients in the design, promotion and evaluation of the program.
- Create a safe, confidential environment for women seeking help.
- Highlight and use individual and collective strengths; do not dwell on weaknesses.
- Use educational approaches that empower participants and are based on the principles of adult education, such as open discussion, question-and-answer sessions and self-help strategies.
- Include activities on stress reduction and building self-esteem in all programs.
- Focus on gender issues and create a profile of women's needs and experiences. Raise community consciousness of rural women's issues.
- Ensure that the program reflects the current context of women's lives (i.e., community norms, socioeconomic status).
- Ensure that all program materials are non-blaming, suitable for a rural context and produced at an appropriate literacy level.
- Train rural women to contact, recruit and assist others like themselves. Rural women need to become resource people for each other and learn to act as speakers, project organizers, lobbyists, advocates, support providers and phone line volunteers.
- Employ facilitators who are skilled in a women-centred, empowering approach.
- Make sure that group facilitators are skilled in the use of a client-centred approach.
- Help facilitators deal with stress-related issues and personal concerns about program delivery.

Stress Mutual Aid and Social Support

- Use teleconferencing or computers for self-help support and networking when it is impossible to bring people together physically.
- Provide recreation activities, meals and socialization opportunities that allow rapport and trust to develop and give people time to make friends and integrate information.
- Provide long-term follow-up for groups and individuals. This helps sustain networks an prevent relapse into old behaviour patterns. it also strengthens the community's ability to provide support in the future.
- Train program graduates to act as "on location" counsellors in remote areas.
- Encourage the use of the buddy system.
- Add a support group (in person or by telephone or computer) to strengthen women's attempts to change a behaviour on their own, or with the assistance of a self help guide.

Overcome Traditional Barriers

Isolation and Lack of Services
All programs require an active outreach component to overcome this barrier. Here are some elements of active outreach:

- Home visiting
- Promotion of toll-free information lines on television and radio
- Provision of subsidized child-care and transportation through volunteers, church-based programs and car-pooling
- Local programming that does not require extensive travel, child-care or time commitments, such as neighbouring, family groups and programs that include children's activities
- Materials that can be used with groups of various sizes in different formats—programs that incorporate children's, women's and men's components or that can be modified for presentation to a variety of community groups such as seniors, community agencies and service providers.

Here are other ways to facilitate outreach:

- Provide formats that accommodate differing schedules and time commitments.
- Offer programs at flexible times—days, evenings and weekends.
- Make or use videos with accompanying study guides. Videos are portable, flexible and easily used by a wide variety of groups. With an accompanying study guide that has a variety of formats, local and regional groups can reach a wide audience.
- Identify and promote available mainstream services and programs in training, counselling, project funding, technical assistance, communications, etc. Many women would use these services if they knew they were available.
- Promote programs in workplaces in small towns.
- Post program information where women will see it—stores, laundromats, libraries, doctors' offices, etc.
- Provide details of what women can expect from your program in all outreach activity information.
- Test the suitability of program information with potential program participants.

- Make presentations at parenting groups, drop-in centres, women's centres and staff meetings. Take a past program participant along (if there is one) to tell what the program was like for her.

- Consider host homes as a way to ensure access to programs dealing with substance use problems, including detox, seniors' intervention and treatment, programs for single mothers and mothers of preschoolers, after-care visitation, etc.

Communication Difficulties

Here are some ideas for overcoming communication difficulties in large regions:

- Develop strong relationships with key local media outlets, e.g., newspaper, radio station, newsletter, electronic bulletin board, cable TV. Be consistent in supplying information.

- Use local and regional institutions to help with communication, e.g., piggyback mailouts with newsletters, annual reports, minutes of meetings, church and health district bulletins, notices in bulletins from professional organizations, other women's groups, farmers organizations, municipal council, etc.

- Send copies of program materials to local and regional public libraries, public health units, clearinghouses and special libraries such as agriculture libraries, farm stress units and school libraries. Provide libraries with a bibliography of materials and a contact list.

Lack of Confidentiality

- Make firm policies on confidentiality and privacy and heavily promote this aspect of your program.

- Harmonize confidentiality provisions with the policies of other community partners and referral agencies.

- Where possible, promote services as open to all, not just to those in crisis. If the service is perceived as open to everyone in the community, then the stigma of seeking help may be reduced or avoided.

- Provide options for individuals who are uncomfortable with public disclosure of substance abuse.

Forge Links and Partnerships Within the Community

- Make clear links between substance use problems and their effect on the community—individuals, families, communities and society at large.

- Address the whole community with varying presentations that stress aspects of substance use problems that are of interest to various community perspectives—seniors, churches, men's service clubs, teachers, health professionals, local government, etc.

- Consider establishing a community advisory committee or board on rural women's issues. Seek out and support community champions.

- Share informal and formal community networks that are already in place. People in every group have an extensive network of contacts that they regularly use in other contexts. Using these networks saves resources and time.

- Partner with at least one other community agency, network or group. Partners can work together on the issue of women and substance use even if this issue is only a minor part of the other organization's mandate.

- Exchange resources with other agencies and groups. List the services your group needs and the community agencies that can provide them. Identify the services that your group can provide to other agencies and make a community match with no money attached.

- Take the time necessary to establish group solidarity on key issues. When you partner with other groups that have different perspectives and backgrounds, it takes time to develop a solid position that will lead to collective action.

- Encourage partners to be involved in at least some program components.

- Include activities for volunteers that are departures from committee work, such as program focus groups, dramas and role plays, celebrations and socialization, speakers' bureaus, study circles, consciousness raising sessions, relaxation and visioning exercises. A variety of activities will attract more women to work on substance use issues.

- Be clear about the purposes and objectives of the program, i.e., prevention, intervention or treatment. Clear objectives support accurate evaluation.

- Evaluate programs using comparisons to other rural programs, not urban programs, since rural residents tend to have slightly different needs and programs have greater per-client costs due to small numbers. Communicate the results to a variety of partners and agencies.

- Reach out to the medical community. Provide information on women's needs and involve women-centred physicians in promoting the program.

- Consider partnering with allied health professionals including dentists, public health nurses and social service workers.

- Offer programs in accessible, non-threatening settings in small towns (e.g., churches, women's centres and community centres).

- Involve local shopkeepers and volunteers who are sensitive to a women-centred approach in making referrals.

VI.
Resource Materials

About This Listing

This is neither a complete nor a comprehensive inventory of resource materials; however, it serves as a useful starting point for practitioners and groups dealing with rural women and substance use.

Please contact the provincial or territorial alcohol and drug office in your area (see Appendix) for more information on resource materials related to women and substance use. Some of these organizations have lists of materials suitable for use with women.

To find out how to obtain a particular resource, please turn to the Distributors' List beginning on page 41.

Inventories and Resource Lists

1. Smoking Cessation Programs: An Inventory of Self-Help and Group Programs
Les programmes de renoncement au tabac : un inventaire des programs individuels et de groupe

Audience: Smokers who want to quit, practitioners

Source: Tobacco Reduction Programs, Health Canada

Year: 1994, updated 1996

Languages: English, French

Distributors: National Clearinghouse on Tobacco and Health, Health Canada, Publications

Description: This inventory provides summary information on a selection of smoking cessation programs and other methods of quitting

Cost: Free

2. Tobacco Resource Material for Prenatal and Postpartum Providers: A Selected Inventory
Répertoire des documents sur le tabagisme pour les dispensateurs de soins prénatals et post-natals

Audience: Prenatal and postpartum providers, practitioners in substance use

Source: Women and Tobacco Reduction Programs, Health Canada

Year: 1995

Languages: English, French

Distributor: Health Canada, Women and Tobacco Reduction Programs

Description: The objective of this booklet is to provide prenatal and postpartum providers with an annotated inventory of resource materials on tobacco for use with their clients. It is one of a series of six booklets on tobacco and pregnancy.

Cost: Free

3. Rural Communities: Alcohol, Tobacco and Other Drugs Resource Guide

Audience: Practitioners

Source: National Clearinghouse for Alcohol and Drug Information (U.S.)

Year: 1994

Language: English

Distributor: National Clearinghouse for Alcohol and Drug Information (U.S.)

Description: This guide includes descriptions of prevention materials, studies, articles and reports related to alcohol, tobacco and other drugs related to rural communities.

Cost: Free

4. *Prevention Resource Guide: Women*

Audience: Practitioners

Source: Office for Substance Abuse Prevention (U.S.)

Year: 1991

Language: English

Distributor: National Clearinghouse for Alcohol and Drug Information (U.S)

Description: This U.S. inventory about women and the prevention of substance abuse contains listings of prevention materials, studies and reports, and groups, organizations and programs.

Cost: Free

5. *National Clearinghouse for Alcohol and Drug Information Publications Catologue*

Audience: Practitioners

Source: Centre for Substance Abuse Prevention (U.S.)

Year: Summer 1995

Language: English

Distributor: National Clearinghouse for Alcohol and Drug Information (U.S.)

Description: This publications catalogue features posters, brochures reports, booklets, audiotapes and videotapes to help in alcohol, tobacco and other drug abuse prevention and awareness efforts. Each group represented in the catalogue offers unique information resources to assist professional and lay audiences, thus providing a full compendium of resources for the prevention community.

Cost: Free

6. *Prevention Resource Guide: Pregnant/Postpartum Women and Their Infants*

Audience: Practitioners

Source: Office for Substance Abuse Prevention (U.S.)

Year: 1991

Language: English

Distributor: National Clearinghouse for Alcohol and Drug Information (U.S.)

Description: This U.S. inventory about women in the pregnancy and postpartum periods and the prevention of substance abuse contains listings of prevention materials, studies and reports, and groups, organizations and programs.

Cost: Free

7. *Alcohol, Tobacco, and Other Drugs Resource Guide-Pregnant Women, Teenagers and Their Infants*

Audience: Practitioners

Source: Centre for Substance Abuse Prevention (U.S.)

Year: 1994

Language: English

Distributor: National Clearinghouse for Alcohol and Drug Information (U.S.)

Description: This U.S. inventory about pregnant adolescents and the prevention of substance abuse contains listings of prevention materials, studies and reports, and groups, organizations and programs.

Cost: Free

Booklets

1. Drug Wise (2 versions) Le Guide (2 types)

Audience: Version 1: Older women living on their own
Version 2: Older women who are in-home caregivers

Source: Action on Women's Addictions—Research & Education (AWARE)

Year: 1992

Languages: English, French

Distributor: AWARE

Description: This 200-page resource manual is printed in large type, on full-size pages, with spiral binding, making it easy to read, handle and photocopy.

Cost: $5 for shipping and handling

2. Making Connections Pensons-y

Audience: Adolescent and adult women

Source: Action on Women's Addictions—Research & Education (AWARE)

Year: 1995

Languages: English, French

Distributor: AWARE

Description: This 84-page booklet examines the connections between the sociopolitical circumstances of women's lives and their use of alcohol and prescription medications, addresses specific life events that make some women more vulnerable to substance abuse, provides tips for using alcohol and medications safely, and gives a list of organizations offering support and other available resources.

Cost: $2.50 for shipping and handling

3. Making the Links

Audience: Young women, 12 to 18 years old

Source: Action on Women's Addictions—Research & Education (AWARE)

Year: 1992

Language: English

Distributor: AWARE

Description: A 23-page booklet that talks about sexual violence, drugs and alcohol

Cost: $2.50 for shipping and handling

4. The Pregnancy and Drug Use Needs Assessment

Audience: Professionals

Source: Action on Women's Addictions — Research & Education (AWARE)

Year: 1994

Language: English

Distributor: AWARE

Description: This needs assessment was conducted with adolescents and women with low incomes to determine what kinds of information they need and in what format it would be best received.

Cost: $12.50

5. The SmokeScreen Needs Assessment

Audience: Professionals

Source: Action on Women's Addictions—Research & Education (AWARE)

Year: 1994

Language: English

Distributor: AWARE

Description: This project determined some tobacco health promotion and cessation strategies for adolescent women.

Cost: $6

6. Women and Drinking Booklet (untitled as yet)

Audience: Women—general

Sources: Addiction Research Foundation

Year: 1996

Languages: English, French

Distributor: Addiction Research Foundation

Description: The booklet discusses the physical and emotional effects of drinking on women; combining alcohol with medications; stress; safe drinking; dependency and where to look for support.

Cost: Undetermined as yet

Note: Available Spring 1996

7. Act Now-Women and Tobacco Femmes et tabac : Passons à l'action!

Audience: Women's groups

Source: Working Group on Women and Tobacco, Steering Committee of the National Strategy to Reduce Tobacco Use in Canada

Year: 1992

Languages: English, French

Distributor: Health Canada, Publications

Description: This booklet examines the issue of women and smoking and suggests ways that groups who are concerned about women can increase the number of Canadian girls and women who are smoke-free. It contains a practical checklist that enables organizations to determine if they are taking a woman-centred approach.

Cost: Free

Note: Sample copy and bulk orders available.

8. Background Paper on Women and Tobacco (1987) and Update (1990) Document d'information sur les femmes et le tabac (1987) : mise à jour (1990)

Audience: Women in general

Source: Health Canada

Year: 1991

Languages: English, French

Distributor: Health Canada, Publications

Description: This paper provides a statistical profile of women and tobacco use and detailed information on women's smoking behaviour in terms of initiation and maintenance of smoking, cessation and recidivism. It focuses on improving our understanding of women's use of tobacco while addressing both health and gender inequities in Canadian society. It includes specific recommendations for future action.

Cost: Free

Note: Sample copy and bulk orders available.

9. Focus on Women and Tobacco
Pleins feux sur les femmes et le tabac

Audience: Women in general

Source: National Clearinghouse on Tobacco and Health

Year: 1993

Languages: English, French

Distributor: National Clearinghouse on Tobacco and Health

Description: This is one part of a fact sheet series developed with the support of Health Canada. It discusses consumption trends, quitting statistics, effects of smoking on women's health, a sociopolitical perspective and future directions.

Cost: Free

10. Taking Control: An Action Handbook on Women and Tobacco
Se prendre en charge : Guide d'action sur les femmes et le tabac

Audience: Women in general

Source: Canadian Council on Smoking and Health

Year. 1989

Languages: English, French

Distributor: Canadian Council on Smoking and Health

Description: This 46-page booklet traces the history of women's smoking, presents information on and interpretation of trends, and explores why women use tobacco in the context of their life experience. It includes a comprehensive section on suggestions for action, from reducing tobacco use to legislating change and relating with the media; it also emphasizes how to be effective and provides a list of resources.

Cost: $5 plus GST

11. Get on Track. A Guide to Help You.Quit Smoking
Montez à bord : Un guide pour aider à cesser de fummer

Audience: Adult smokers who want to quit

Source: Lung Association

Year: 1994

Languages: English, French

Distributor: Lung Association

Description: A self-help program for people who want to quit. The brightly coloured pocket-sized booklet is written at a grade 6 reading level and provides practical help to stop smoking.

Cost: Contact your local or provincial Lung Association for availability and cost.

12. Women and Tobacco. A Framework For Action
Les femmes et le tabagisme : plan d'action

Audience: Practitioners

Source: Health Canada

Year: 1995

Languages: English, French

Distributor: Health Canada, Publications

Description: Proceedings from the 1995 national conference on women and tobacco.

Cost: Free

13. *A Guide for Planning Withdrawal Management Services in Rural and Remote Areas and Small Urban Centres of Ontario*
Guide de planification des services de gestion du sevrage dans les petits centres urbains, les collectivités rurales et les régions éloignées de l'Ontario

Audience: Community-based planning groups

Source: Addiction Research Foundation (Ontario)

Year: 1994

Languages: English, French

Distributor: Addiction Research Foundation (Ontario)

Description: This guide is designed to enable community-based planning groups to create, implement and evaluate relevant, cost-effective withdrawal services in small urban and rural and remote areas. Written in step-by-step format, the book provides a summary and questions at the end of each chapter. The experience of one local planning group provides concrete examples of how the framework can be adapted to meet the needs of a particular community.

Cost: $31.95; a special price of $15.95 (plus shipping, handling and GST) is available to Ontario government-funded agencies.

Guidebooks and Kits

1. *Alternatives. Prevention and Intervention for Alcohol and drug Problems in Seniors*
Options. Prévention et intervention conçernant les problèmes d'alcool et de drogue chez les aînés

Audience: Seniors, people working with seniors

Source: Addiction Research Foundation (Ontario)

Year: 1993

Languages: English, French

Distributor: Addiction Research Foundation (Marketing Services)

Description: Alternatives provides an overview of the unique stresses seniors face, including decreased tolerance to alcohol and drugs and the potential misuse of prescription and over-the-counter drugs. This kit includes a video, overhead masters, masters for handouts, background information on seniors and drug use, a step-by-step guide for delivering great presentations and pamphlets from the *Older Adult* series.

Cost: $115 plus applicable taxes; $55 within Ontario

2. *LESA Manual: A Program of Lifestyle Enrichment for Senior Adults with Alcohol and Other Psychoactive drug Problems*
LESA : Programme d'enrichissement de la vie des aînés souffrant de dépendence l'egarde de l'alcool et d'autre psychotropes

Audience: Older adults 55-plus

Source: Centretown Community Health Centre

Year: 1992

Languages: English, French

Distributor: Addiction Research Foundation (Ontario)

Description: A manual for providers who wish to offer the LESA program for older adults.

Cost: $15.

3. *Hidden Majority. A Guidebook on Alcohol and Other Drug Issues for Counsellors Who Work With Women (French-undetermined at time of writing)*

Audience: Health and social service providers

Source: Addiction Research Foundation (Ontario)

Year: 1996

Languages: English, French

Distributor: Addiction Research Foundation

Description: The guidebook is designed for people working with women. It addresses topics such as how substances affect women, how t identify when alcohol or other drug use is a problem, guidelines for safe use of alcohol and other drugs, and how to intervene and make appropriate referrals. It also suggests alternatives that enhance womens' health.

Cost: Undetermined as yet

Note: Approximately 100 pages. Available Spring 1996.

4. *LINK Educational Package. Violence Against Women and Children in Relationships and the Use of Alcohol and Drugs*
LIEN : Violence contre les femmes et les enfants dans les celations et l'usage d'alcool et des drogues

Audience: Service providers in the addictions and family violence fields

Source: Addiction Research Foundation (Ontario)

Year: 1995

Languages: English, French

Distributor: Addiction Research Foundation

Description: The LINK educational package includes a trainees guidebook, overhead masters, information on resource materials on substance use, information on violence against women and children in relationships and the link between the two, and a 15-minute video designed to trigger discussion in a workshop setting.

Cost: $50 plus $5 shipping and handling and applicable taxes

Note: LINK offers practical advice to service providers on how to identify violence and substance use issues and how to get appropriate help for their clients.

5. *Saying When: How to Quit Drinking or Cut Down*
C'est assez! Comment arrêter de boire ou réduire votre consommation d'alcool

Audience: Adults

Source: Addiction Research Foundation (Ontario)

Year: 1994, 2nd edition

Languages: English, French

Distributor: Addiction Research Foundation

Description: This 79-page manual dispels myths about drinking and offers a step-by-step self-help program for effectively cutting down or quitting drinking. It provides privacy, confidentiality and the option to set your own goals for success.

Cost: $24.95 plus applicable taxes.

6. *Alcohol and Drugs Are Women's Issues, Vol 2, The Model Program Guide*

Audience: Women

Source: Roth, Paula (1991). Metuchen, NJ: The Women's Action Alliance and the Scarecrow Press Inc.

Year: 1991

Language: English

Distributor: Addiction Research Foundation (Marketing Services)

Description: This volume contains a number of program descriptions, mainly involving treatment. It is a pragmatic guide with a feminist, holistic approach.

7. *Catching Our Breath: A journal About Change for Women Who Smoke and A Guide for Facilitators*

Audience: Women smokers

Source: Women's Health Clinic, Winnipeg, Manitoba

Year: 1990

Language: English

Distributor: Women's Health Clinic, Winnipeg, Manitoba

Description: Each volume includes two guides. The journal for women who want to stop smoking provides a holistic self-help program using journal writing, positive affirmations, supportive environments, internal change and how to information on quitting and avoiding relapse (128 pages). The facilitators guide discusses how to create an effective group environment and how to use the journal as the basis for a group smoking cessation program (100 pages).

Cost: $12 per volume, plus $1 shipping and handling

Note: Participants must be comfortable with reading and writing. Sample copy and bulk orders available.

8. *How to Talk About Smoking with High Risk Pregnant Women: A Guide for Support Providers*
Comment discuter le sujet du tabac avec les femmes enceintes haut risque : Un guide pour les personnes soutien

Audience: Support providers who have contact with pregnant women during prenatal orpostpartum periods

Sources: Council for a Tobacco-Free Ontario; Heart and Stroke Foundation of Ontario; Canadian Cancer Society; Lung Association

Year: 1994

Languages: English, French

Distributors: Council for a Tobacco-Free Ontario; Heart and Stroke Foundation of Ontario; Canadian Cancer Society; Lung Association

Description: This guide covers how to bring up the topic of smoking, how to use available resources, how to develop a plan, how to obtain partner and family support, how to incorporate smoking with other prenatal issues and how to deal with barriers to success and relapse. It also emphasizes the importance of the postpartum period.

Cost: Contact a local or provincial distributor's office for availability and cost.

9. *Quit 4 Life*
Une vie 100 fumer

Audience: Young smokers

Source: Health Canada

Year: 1993

Languages: English, French

Distributor: Health Canada, Publications

Description: This is a package of information designed to help adolescent smokers quit. It guides the smoker through the stages of quitting and does not minimize the difficulties. Teen smokers were consulted at all stages of the development of the program and their input significantly influenced the final product (shaped like a compact disc).

Cost: Free

Note: A sample copy is available. The package is available free to teen smokers who are motivated to quit smoking: 1-800-363-3537.

Videos

1. *Women and Substance Use: Sharing Our Experiences*

Audience: Women of all ages, counsellors, health and social service providers, educators, community groups, volunteers and students

Source: Canadian Public Health Association

Year: 1995

Language: English

Distributor: Canadian Public Health Association

Description: This 16-minute video follows the four major life stages of women (adolescence, young adulthood, mid-adulthood and senior years) with the goal of raising awareness, providing support and initiating discussion. A 26-page discussion guide providing an overview of the Video and ideas for its use is included.

Cost: $18.95 plus shipping and handling and applicable taxes

2. *Women and Chemical Dependency*

Audience: Adults

Source: Saskatchewan Health

Year: 1991

Language: English

Distributor: Media House Productions Inc.

Description: This video and guide look at gender differences in chemical use, conditions that influence chemical use, barriers to treatment and treatment issues and models.

Cost: Minimal fee

Note: Available in Saskatchewan only.

3. *Health Promotion Video on Women, Substance Use and Wellness (untitled at time of writting)*

Audience: Women-general

Source: Addiction Research Foundation

Year: 1996

Language: English

Distributor: Addiction Research Foundation

Description: This 27-minute video documents the lives of six women who talk about stress in their lives and how they cope

Cost: Undetermined as yet

Note: Available Spring 1996.

4. *Diary of a Teenage Smoker*
Journal d'une jeune fumeuse

Audience: Adolescent women

Source: Health Canada

Year: 1989

Languages: English, French

Distributors: Health Canada, Women and Tobacco Reduction Division; Heart and Stroke Foundation of Canada; Canadian Cancer Society

Description: This video looks at young teenage females' experience with tobacco addiction. All narration is performed by teenagers, adding influence to strong anti-tobacco, pro-health messages. The Globe and Mail's television critic called this documentary "sparkling, entertaining and informative". VHS, 28 minutes.

Cost: Available on loan from Health Canada

Note: Comprehensive teaching guide available with video.

5. *The Feminine Mistake.*
The Next Generation
L'erreur féminine :
La prochaine génération

Audience: Young women

Source: Pyramid Films

Year: 1989

Languages: English, French

Distributor: Omega Films Limited

Description: This video highlights the health risks of smoking for women by showing the role that advertising and promotional images play in recruiting a new generation of smokers. It includes current statistics as well as interviews with women whose lives have been severely damaged by smoking. The video was rated 4 on a 6-point scale by the Addiction Research Foundation. VHS, 30 minutes.

Cost: $526; may also be rented

Note: 15% discount when both languages are purchased at the same time. Available on loan from some offices of the Lung Association and Canadian Cancer Society.

Other

Television Public Service Announcement (PSA)

1. *Violence Against Women and Substance Use*
(French title — in translation)

Audience: Abused women in rural areas

Source: Addiction Research Foundation (Ontario); Renfrew County Women and Substance Abuse Committee, Renfrew Country Committee for Abused Women

Year: 1996

Languages: English, French

Distributor: Addiction Research Foundation

Description: This 30-second television PSA will raise awareness among rural women who are being abused by their partners and may be using alcohol or drugs to cope. The PSA assures women that they are not alone, that there is a safe way out and that help is available for both the violence and substance use problems.

Cost: $15 plus shipping, handling and taxes

Note: In production at time of writing.

2. *FAS/FAE Information Service, Canadian Centre on Substance Abuse*

Description: A wide range of information on FAS/FAE is available to a variety of clients including caregivers, educators, social workers, health care and treatment professionals, researchers, policy makers, members of the legal community and the general public. It also provides networking services to other FAS/FAE specialists, community support groups and prevention programs.

3. *National AIDS Clearinghouse, Canadian Public Health Association*

Description: The Clearinghouse has a permanent collection of thousands of materials developed both in Canada and internationally addressing all areas of AIDS awareness, prevention, education and treatment. Most of these publications are available free-of-charge. Materials that are not available for general distribution are available on loan within Canada through a free lending library. The Clearinghouse also performs customized searches of their own and external databases.

4. *National Clearinghouse on Family Violence, Health Canada*

Description: The Clearinghouse is a national resource centre for people who are looking for family violence information and resources, including articles, fact sheets, reports, brochures, posters and information kits. The Clearinghouse also provides a referral and directory service of organizations and resource people working in the field.

5. *National Clearinghouse on Substance Abuse, Canadian Centre on Substance Abuse*

Description: The mandate of the Clearinghouse is to improve access to Canadian information on alcohol and other drugs. The Clearinghouse coordinates the Canadian Substance Abuse Information Network (CSAIN), a service which links the major substance abuse libraries and resource centres in Canada. The Clearinghouse responds to requests for information using in-house databases, their document collection and the CSAIN network. It also collects hard-to-obtain Canadian substance abuse resources and maintains a homepage on the World Wide Web, from which clients can access information on their own.

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References

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